VERMONT STATEWIDE HEALTH REFORM DEMONSTRATION

FACT SHEET

Name of Section 1115 Demonstration:	Vermont Health Access Plan (VHAP)
Date Proposal Submitted:	February 24, 1995
Date Proposal Approved:	July 28, 1995
Date Implemented:	January 1, 1996
Date Extension Request Submitted:	December 7, 1999
Date Extension Request Approved:	June 5, 2000
Date Extension Expires:	December 31, 2003

SUMMARY

The Centers for Medicare & Medicaid Services (CMS) approved Vermont's Medicaid section 1115 demonstration proposal entitled "The Vermont Health Access Plan (VHAP)" on July 28, 1995. Originally, the program provided health care coverage to uninsured adults up to 150 percent of the Federal Poverty Level (FPL). Children had already been covered up to 225 percent FPL since 1992 through the State plan. Through numerous amendments to the demonstration, coverage has now been extended to 300 percent FPL for children and up to 185 percent FPL for parents and caretakers of Medicaid-eligible children. VHAP eligibles include:

- traditional Medicaid eligibles
- *un*insured expansion individuals
- *under*insured expansion individuals
- low income elderly or disabled individuals (pharmacy benefit only) through the VHAP Pharmacy and VScript Programs
- adults enrolled in a long-term behavioral health services program, known as the Community Rehabilitation and Treatment (CRT) program

As approved in 1995, the demonstration used capitated managed care organizations (MCOs) to deliver acute care services to both the uninsured expansion population and the traditional Medicaid population. On September 29, 1999, CMS approved a primary care case management

(PCCM) fee-for-service (FFS) model for aged, blind, and disabled (ABD) individuals, as the MCOs were no longer willing to accept full risk for this population. Then, on October 28, 1999, CMS approved the expansion of the PCCM model for all other groups receiving acute care services under VHAP (both expansion and traditional Medicaid), in anticipation of one of the MCO's exit from the Vermont market.

On June 5, 2000, Vermont received approval of a three-year extension of VHAP through December 31, 2003. As of June 2002, the demonstration covers approximately 85,000 individuals, around 24,000 of whom are individuals who would not otherwise be eligible for Medicaid. Moreover, more than 12,000 low-income elderly and disabled individuals are eligible for the pharmacy-only benefit through VHAP Pharmacy and VScript.

ELIGIBILITY

- All current Vermont Medicaid eligible groups are included in VHAP except dual eligibles, individuals participating in any home and community-based waiver, individuals who spend down and become eligible for the Medically Needy program, individuals receiving care in long-term care facilities, and individuals with other physician or hospital coverage.

- Eligibility was initially expanded to uninsured adults with income up to 150% FPL and was provided through simplified income criteria, i.e., no categorical requirements or resource/assets tests for new eligibles. Eligibility was expanded to parents and caretaker relatives of Medicaid-eligible children up to 185% FPL on February 26, 1999.

- Under the original demonstration design, elderly or disabled individuals living in households with income up to 150 percent FPL were eligible for a Medicaid pharmacy-only supplemental benefit through the VHAP Pharmacy program. Eligibility for the pharmacy benefit was expanded to 175% FPL for maintenance medicines on February 26, 1999 (the VScript program).

- As a complement to Vermont SCHIP, which covers *un*insured children between 225% and 300% FPL, an amendment to the demonstration was approved on November 6, 1998 which provides health care services to *under*insured children between 225 and 300 percent FPL.

BENEFIT PACKAGE

- Individuals who are eligible for the Vermont Medicaid program under federally defined and mandated requirements ("traditional eligibles") are eligible for any Medicaid-covered service or program as described in the Medicaid State Plan. These individuals are eligible for non-emergency transportation services and personal care services for children, services not included in the benefits package for expansion eligibles.

- Expansion eligibles receive a comprehensive benefit package similar to commercial

health benefits packages offered to other Vermonters who are adequately insured in the private sector.

- The prescription drug coverage offered to low income elderly and disabled individuals is an expansion of the existing fee-for-service pharmacy benefit for low-income Vermonters.

- Vermont has structured an innovative mental health and chemical dependency benefit within the Medicaid managed care arrangement. Mental health and chemical dependency benefits are based solely on an assessment of each individual's medical need.

ENROLLMENT/DISENROLLMENT PROCESS

- The State has contracted with Maximus, a Benefits Counseling contractor, who facilitates eligible individuals' participation in VHAP and enrollment in the PCCM model. The Benefits Counseling contractor is responsible for outreach, education, and enrollment of expansion and traditional eligibles.

DELIVERY SYSTEM

- Vermont previously contracted with two MCOs, Kaiser and BlueFirst (Blue Cross/Blue Shield of Vermont) to provide services to the traditional Medicaid and expansion populations.

- However, Kaiser has since exited the Northeastern market, including Vermont. Blue Cross/Blue Shield of Vermont and the State mutually agreed to terminate the BlueFirst program. On October 28, 1999, CMS approved the State's proposal to implement a PCCM model for the populations previously served by MCOs.

- Traditional eligibles will always have a choice of at least two providers under the amended demonstration. The State will attempt to ensure that expansion eligibles have a choice of at least two providers as well.

QUALITY ASSURANCE

- The State has developed quality assurance measures and has contracted with a quality assurance contractor.

COST-SHARING

- For previously-uninsured expansion eligibles, an *enrollment fee* between $10 and $50 for each adult not otherwise eligible for Medicaid coverage is charged for each 6-month enrollment period. These biannual fees apply to expansion eligibles between 50% and 185% FPL.

- Households with underinsured children whose family income is between 185% and 225% pay a $20 *monthly premium*, and those between 225% FPL and 300% FPL pay a $24 *monthly premium*.

- For those eligibles that the State could have elected to enroll in Medicaid absent the demonstration and would be regarded as categorically needy, no monthly premiums are imposed except for those noted above -- for households with children whose family income is above 185% FPL.

- Expansion eligibles are subject to service-specific cost-sharing up to an annual out-of-pocket maximum of $750 for a single person and $1,500 for families.

- A $1 to $3 copayment on prescriptions and refills is charged to low-income elderly and disabled individuals receiving the pharmacy-only supplemental benefit.

Revised 9/16/02